

# Georgia Cumberland Conference Health History Form

Applicant's Legal Name:	Birthdate: ____/____/____ Month / Day / Year	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
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Club Name:	Director Name:
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Mailing Address

City	State	Zip
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If a child, who has legal custody?  Both Parents  Mother  Father  Other \_\_\_\_\_

**Primary contact in case of illness or injury for child it must be a Parent/Guardian with legal custody:**

Name:	Relation to Applicant
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Primary Phone: ( ) ( ) ( )	Alternate Phone: ( ) ( ) ( )
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**2nd parent/guardian or other emergency contact (optional):**

Name:	Relation to Applicant
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Primary Phone: ( ) ( ) ( )	Alternate Phone: ( ) ( ) ( )
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**Additional contact in event parent/guardian(s) cannot be reached (optional):**

Name (s):	Relation to Applicant
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Primary Phone: ( ) ( ) ( )	Alternate Phone: ( ) ( ) ( )
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**Health Care Providers**

Physician	City	Office Phone: ( ) ( ) ( )
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Dentist	City	Office Phone: ( ) ( ) ( )
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Orthodontist	City	Office Phone: ( ) ( ) ( )
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**Health Insurance Information**

Is applicant covered by family health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder
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Insurance Company	Phone: ( ) ( ) ( )	Holder's Birthdate: ____/____/____ Month/ Day/ Year
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Employer	Policy Number:	Group Number:
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**Immunizations**

Are all your immunizations, required for school, up-to-date?      Yes       No

**Tetanus Status:** Month \_\_\_\_ Year \_\_\_\_ (The month and year of the most recent Tetanus shot is **required**)

If doctor advises, may Tetanus Immunization be administered?       Yes       No

***If applicant has not been fully immunized, please sign the following statement:***

*I understand and accept the risks from my/my child not being fully immunized.*

\*Legal Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**General Health History:** Check "Yes" or "No" if the child has or had a history of the following:

1. Asthma/wheezing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	10. Seizure Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	11. Fainting or dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Back or joint problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	12. Heart Condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	13. Stomach Upsets	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	14. Sprain, Dislocation etc	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Constipation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	15. Sleep problems or Sleepwalking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	16. Recurrent/chronic illnesses.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Ear Infections/Ear Tubes (circle)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	17. Communicable (Infectious) Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Frequent Sore Throats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	18. Eye Glasses/Contacts (circle)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other (not listed) _____					

**List any hospitalizations, Surgeries or Broken Bones:**

Year	Hospitalization/Surgery/Broken Bones	Explanation

# Georgia Cumberland Conference Health History Form (continued)

Applicant's Legal Name:	Birthdate: ____/____/____ Month / Day / Year	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Club Name:	Director Name:	

**Allergies:**  
 No known allergies  
 This applicant is allergic to  Food(s)  Medicine  Environment (insect, pollen, etc.)  Other

List all Allergies:	Reaction

**Medications/Vitamins/Natural Remedies Applicant Needs (to be provided by Parent/Guardian):**  
 This applicant will **not** take any daily medications while attending events.  
 This applicant will need to take the following medications while attending events:  
**List medications, vitamins, etc. to be taken:** (Any psychotropic drugs must be at the therapeutic level – 3 months minimum use.)

Medication Name	Dose	Frequency	Reason	What happens if dose is missed?
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		

**\*If a child all medications, vitamins or natural remedies (prescription and/or over-the-counter) must be brought in the original bottle and turned into the Director by the parent/guardian.**

**OTC Medications:** Please mark Yes if you approve or No if you do not approve for the below over the counter medicines to given to the applicant in the event of a minor illness by the designated staff.

<p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Acetaminophen (Tylenol)</p> <p><input type="checkbox"/> <input type="checkbox"/> Ibuprofen (Advil, Motrin)</p> <p><input type="checkbox"/> <input type="checkbox"/> Throat lozenges for sore throats</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat spray (Chloraseptic)</p> <p><input type="checkbox"/> <input type="checkbox"/> Calamine lotion</p> <p><input type="checkbox"/> <input type="checkbox"/> Antibiotic cream</p> <p><input type="checkbox"/> <input type="checkbox"/> Aloe</p> <p><input type="checkbox"/> <input type="checkbox"/> Ointment for rash (Hydrocortisone)</p> <p><input type="checkbox"/> <input type="checkbox"/> Laxative for constipation</p>	<p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Diphenhydramine antihistamine/allergy medicine (Benadryl)</p> <p><input type="checkbox"/> <input type="checkbox"/> Antihistamine/allergy medicine (Zyrtec/Claritin)</p> <p><input type="checkbox"/> <input type="checkbox"/> Pseudoephedrine decongestant (Sudafed)</p> <p><input type="checkbox"/> <input type="checkbox"/> Phenylephrine decongestant (Sudafed PE)</p> <p><input type="checkbox"/> <input type="checkbox"/> Guaifenesin cough syrup</p> <p><input type="checkbox"/> <input type="checkbox"/> Dextromethorphan cough syrup</p> <p><input type="checkbox"/> <input type="checkbox"/> Bismuth subsalicylate for diarrhea (Immodium, Pepto-Bismol)</p> <p><input type="checkbox"/> <input type="checkbox"/> Upset stomach/nausea/indigestion (Tums, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>
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If there are any restrictions on Activities or Diet please note here:

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**Parent Authorization for Treatment – required for those under 18 years of age.**

This health history is correct and accurately reflects the health status of the applicant as far as I am aware. If a child, applicant will turn in all medications to the Director and will take any and all prescribed medications sent by the parent/guardian. I give permission to the designated staff to give over-the-counter medications as indicated above. If I cannot be reached in an emergency, I give permission to the physician selected by the designated staff to examine, order any x-rays or routine tests, to hospitalize, secure proper treatment, order injections, anesthetic, medical and/or surgical treatment to said minor. I understand the information on this form will be shared on a "need to know" basis with the staff. In addition, the staff have permission to obtain a copy of my/my child's medical record from providers who treat me/my child and these providers may talk to the attending staff about my/my child's health status. I hereby authorize any hospital or physician, or any other person who has attended or examined me/my child to furnish the insurance company or its representative any and all information with respect to any illness, injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records in regards to receiving payment for their services. I accept the conditions stated, including the release of the Georgia Cumberland Conference management from liability in case of serious injury or death. I hereby give my consent for me/my child to participate in all activities. This consent shall remain in continuous effect until revoked in writing. A photo copy of this form shall be as effective and valid as the original.

/ /	Date	Relation to Applicant
*Applicant or Custodial Parent/Guardian's Signature		

\*This form is to be completed and signed by the primary parent/guardian whose name appears on the front page.

Please Note: Health insurance remains the family's responsibility to provide.